STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, *Governor*

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814

(916) 323-0503

November 18, 1988
CMSP Letter 88-11

TO: All County Welfare Directors

SUBJECT: CMSP Record of Health Care Costs-Spenddown (CMSP-177P)

This memo transmits to you a camera ready copy of the revised CMSP Record of Health Care Costs-Spenddown (CMSP-177P). This form is used in the eligibility determination process when the property reserve exceeds the property limit. The excess property reserve must be spent for medical bills incurred during the month for which coverage is requested.

Upon receipt of this letter, the county is responsible for the immediate reproduction of an adequate supply of this form, using the camera-ready copies enclosed. The county's remaining supply of any outdated notices are obsolete and must be destroyed.

Please contact Al Cooper of the CMSP Unit at (916) 324-4892, if you have any questions concerning this notice.

Sincerely,

Jim Martinez

Jim Martinez, Chief
County Medical Services Program

Enclosures

cc: CMSP Contact Persons (w/o enclosures)

SI:tn

State of California—Health and Welfare Agency

Department of Health Services

COUNTY MEDICAL SERVICES PROGRAM (CMSP)
RECORD OF HEALTH CARE COSTS – SPENDDOWN

Read instructions on back of this form before completing.

Case Name — First, Middle, Last

City, State, Zip Code

Medical expenses incurred in the month of application may be listed below when you have paid for them.

Mo. _____ Yr. _____

Co. Dist. | COUNTY USE

SPENDDOWN

The amount family members must pay for medical expenses:

$ _____

Family members ☐ will ☐ will not be required to pay or obligate an additional amount toward medical expenses (Form CMSP 177-S) for the month(s) listed above.

Medical expenses of family members listed below may be used to meet the spenddown

State Number Co.	Aid	PERS.	Name — Last, First, Middle	Birthdate Mo. Day Yr.	Sex	Other Cov. Code	(1) Social Security No. (2) HIC or RR No.
							(1) (2)
							(1) (2)
							(1) (2)
							(1) (2)
							(1) (2)
							(1) (2)
							(1) (2)

Declaration of provider: Each service listed below has been provided to the person listed on the date specified. I, the undersigned provider hereby declare that I received payment from the patient for the amount shown in the "Paid By Patient" column and that I will neither claim nor accept payment from the CMSP for that amount. I also understand and agree that I may seek payment from the CMSP for the costs of CMSP covered services in excess of the amount paid by the patient if the patient becomes eligible for CMSP and meets any additional share of cost.

I understand that if I bill insurance or any other third party for the service rendered, I cannot list on this form the service to be paid or the charge.

I am aware that financial information on this form may be subject to scrutiny by the Internal Revenue Service and/or the California State Franchise Tax Board.

Provider Name / Patient Name / Provider Signature (See Declaration Above)	Provider No.	Date of Service Mo. Day Yr.	Service	Proc. Code/ Presc. No.	Total Bill $	Paid By Patient $
Provider Name / Patient Name / Provider Signature (See Declaration Above)	Provider No.					
Provider Name / Patient Name / Provider Signature (See Declaration Above)	Provider No.					
Provider Name / Patient Name / Provider Signature (See Declaration Above)	Provider No.					
Provider Name / Patient Name / Provider Signature (See Declaration Above)	Provider No.					

STATE USE ONLY

Date Of Certification Mo. Day Yr.

I have read the instructions on the back of this form. I have paid the amounts listed above in the "Paid By Patient" column.

Signature of Applicant _____ Date _____

Instructions to Patient:

On the other side of this form, the amount you must pay before you are eligible for CMSP is shown in the space labeled "Spenddown." Take this form with you to any doctor, druggist, hospital, or any other provider of medical care in the month(s) specified. Be sure to tell the medical provider that you have a CMSP number and give him this form. He will fill in the amount of his total bill and the amount you must pay; the amount you must pay should not be more than the amount listed in the "Spenddown" space. *When you have paid this amount, do not pay any more.* After you have reached the amount you must pay, sign your name and enter the date at the bottom of the form. Keep the last copy for your records. Send the original and the other two copies to your county department. If this form is approved, you are determined eligible, and any other forms your worker asks you to complete are approved, you will receive a CMSP card. As soon as you get your CMSP card, take it to the providers of medical services who have signed the front of this form so they can bill CMSP for the services for which they have not been paid. If you have any problems in using this form, call your eligibility worker.

The types of services which can be listed on this form are:

Physician
Dental
Prescribed Drugs
Laboratory
X-Rays
Chiropractic
Clinical Psychology [only institutional as in Hospital Care (Inpatient or Outpatient), Other Organized Outpatient Care, and Short-Doyle Clinic]
Assistive Devices (e.g., crutches, wheelchairs, walkers, etc.)
Blood
Optometrists
Christian Science Facilities
Christian Science Practitioner
Hospital Care (Inpatient or Outpatient)
Nursing Home Care
Other Organized Outpatient Care
Prosthetic or Orthotic Appliances
Physical or Occupational Therapy
Speech Therapy
Essential Medical Transportation
Podiatry
Optician
Short-Doyle Clinic
Audiologists
Hearing Aids
Home Health Agencies

Instructions to Providers:

This form is to be used to establish eligibility for CMSP payment for the persons listed on this form. The following verification is required: that the patient has paid the amount listed in the space labeled "Spenddown," and that the patient has obtained the provider's declaration that payment was received. The provider's signature meets this requirement.

In completing the form, please observe the following:

1 Be sure the services listed were provided in the month listed at the top of the form.

2. Fill in your name, provider license number, and the exact dates of service. Do *not* list dates such as April 2 through April 10, but list each separate day, month, and year on which services were provided.

3. In the space marked "Total Bill," enter the total charge for service. Do *not* enter in this space any amount billed to Medicare.

4. In the "Paid by Patient" space, list only the amount the patient is to pay. This amount is *not* to exceed the amount entered at the top of the form in the "Spenddown" space. If other providers have made entries on the form, make sure their charges to the patient plus your charges do *not* exceed the amount in the "Spenddown" space.